NEW YORK NEUROLOGICAL SOCIETY.

January 1, 1901.

The President, Dr. Frederick Peterson, in the chair.

SPINAL ACCESSORY PARALYSIS.

Dr. Pearce Bailey presented a man who last March had been operated upon for suppurating glands of the neck. During the operation the spinal accessory nerve had been cut. There had been immediate and complete paralysis of the sterno-mastoid and trapezius. About six weeks later the nerve had been sutured, with considerable improvement in the symptoms. During the past summer weakness had appeared in the deltoid and in the muscles supplied by the musculospiral nerve. There had been considerable return of power. A fairly large incision had been made at the operation in the region of the mastoid. On inspection, the shoulder on the affected side was seen to droop, and the scapula hung away from the spine. The only anesthesia observed had been limited to the ear and the right side of the face—an area corresponding to the supply of the great auricular nerve, which had undoubtedly been cut at the same time. There was now marked hyperesthesia over the distribution of this nerve. When first seen the position of the head had been slightly towards the injured side and a little downward.

Dr. E. D. Fisher suggested that there was a psychical element in the case. On pressing along the muscles of the arm slowly there was no reaction, but if this pressure were exerted suddenly there was a spasmodic contraction of the muscles of this region.

Dr. Joseph Collins did not think the whole condition had been explained by Dr. Bailey, for, in his opinion, there were symptoms of root involvement over a rather extended area. He could not understand how these could be explained by a mere section of the spinal accessory nerve. The tic of the facial muscles and on either side of the neck, and the narrowing of the palpebral fissure appeared to be associated with fibrillary twitchings. This would indicate a rather extensive involvement of the anterior roots in the cervical region. He would also like to know about the condition of the pupils.

Dr. F. Peterson said that he had seen this case before, and had been interested in the complications. He had seen the man before the appearance of the twitchings, and on first observing the latter he had been inclined to assume that the case was hysterical. However, after having made the electrical examination he had felt sure that it was not hysterical, but one of pressure palsy involving a number of nerves, possibly as a result of sleeping with the arm in an upward position.

Dr. Bailey said that the suppurating gland had been situated deeply underneath the sterno-mastoid. When the patient was first seen by him last April there was a typical picture of paralysis of the sterno-mastoid and trapezius, but no symptoms referable to the arm, no tics and no functional disorders. The man had been completely

incapacitated for work, and this probably explained his psychical condition. The irritative condition of the face was probably explicable by the formation of new connective tissue in the scar. As soon as his attention had been called to the pressure palsy he had been watched at night and prevented from sleeping on his arm, and this had resulted in immediate and decided improvement. It was probable that in time the man would get fairly good use of his arm.

FACIAL HEMIATROPHY.

Dr. Max Mailhouse presented a man, twenty years of age, without neurotic family history. Twenty-two months ago a discoloration had appeared on the right side of the face below the lower lid. It had begun as a pale depressed spot. When first seen by the speaker, the right side of the face had been much atrophied, and the beard had been absent on this side. The mouth had been drawn to the right and the right half of the tongue was very much atrophied. The apparent prominence of the right eyeball was due to retraction of the lower lid. The hair of the right half of the scalp was grayer than on the left, and was falling out. He had been losing his teeth on the right side. The nasal cartilage was wasted, and its tip was turned to the right. The muscles of mastication were also atrophied, and this atrophy was associated with spasmodic pain. There was a fibrillary tremor of the large muscles. The affected muscles reacted feebly to faradization, and normally to galvanism. No scleroderma was found. For the past two months there had been twitching of the muscles at the right angle of the mouth, and at times after laughing, this angle would remain retracted. At such times there was a very tender spot in front of the ear. A blow of moderate severity had been received over the mouth ten years ago. No other etiological element could be elicited, and even this one seemed to have but little weight. The atrophy of the tongue seemed to be a strong argument for the theory that this affection is a tropho-neurosis.

Dr. C. L. Dana said that he had met with several such cases, and found them all quite obscure. At one time the view had prevailed that it was a tropho-neurosis due to some lesion of the trophic root —a condition very difficult to understand. In one of his cases there had been a typical diffuse trigeminal neuritis occurring in a woman of about forty years. The attack had begun with herpes and neuralgia, and had been followed by a general neuralgia in the course of the fifth nerve. After this there had been atrophy and some anesthesia, and finally a peculiar pitting of the face, like that from smallpox. In another case, the trouble had begun, as it often did, with pigmented spots and neuralgia, and this had been followed by anesthesia in spots and a typical progressive anesthesia involving all the tissues, including the masseter muscle and the bone. In this woman there had been deafness and some disturbance of vision on the affected side. It was difficult to understand how a trophic or cen-

tral lesion could cause all these symptoms. A herpes was almost always a sign of peripheral trouble. Another case had been in a woman who had married at the age of seventeen. Her husband had died, it was said, of syphilis a few years later, though the woman denied ever having become infected. She had had a progressive facial hemiatrophy for a number of years, and had finally developed atrophy on the same side, affecting the arm and the leg. In none of his cases had there been anything indicating the true nature of the etiology. Perhaps the best explanation was that of a peripheral lesion as a starting point. He had obtained no definite results from treatment, perhaps because he had not been able to keep these cases under treatment for a sufficient length of time. If the trouble were peripheral, Dercum's idea of resecting the trigeminus seemed to be worthy of consideration.

Dr. Fraenkel asked if any difference had been observed in the behavior of the sweat glands on both sides of the face.

Dr. Mailhouse replied that there had been less sweating on the affected side.

Dr. Jospeh Collins thought the disease could be explained just as well by a central as by a local lesion. He was inclined to think that the patient just presented had a lesion in the pons, in the area of central representation of the sympathetic nervous system in the pons. The lesion was probably a slowly progressive one such as a gliomatosis. There already seemed to be involvement of the motor nuclei of the medulla oblongata. The enlargement of the pupil would be explained by an irritation of the sympathetic which had gone on to paralytic effects.

Dr. C. L. Dana presented in connection with the last case a rather rare form of progressive lingual hemiatrophy. It occurred in a man, twenty-six years of age, who had had the trouble three years but had been otherwise in perfect health. The half of the tongue was slightly wasted, and this atrophy was associated with fibrillary twitchings. The patient was a healthy young medical student without history of syphilitic infection or nervous heredity. It did not seem to him necessary to suppose that there was a gliosis, for, Mendel had already shown that there is a change in the motor root of the trigeminus. Of course, these changes might be secondary to degeneration and partial destruction of the nerve.

Dr. Peterson said he was inclined to believe with Dr. Collins that some central lesion would best explain the condition. He had seen several cases, but all of them in a much earlier stage. In none of them had the tongue or the muscles of mastication been involved, or had they presented the same pupillary phenomena.

Dr. Mailhouse thought the dilation of the pupil might be explained by a similar process involving the sphincter pupillae and causing weakness. Hoffman had reported some improvement from the use of galvanism for half an hour daily.

At a meeting of the New York Neurological Society held January 1, 1901, the following report was read and unanimously adopted:

The Committee of the New York Neurological Society, appointed at the request of the President of the New York Commission in Lunacy, to offer suggestions as to a scheme of scientific study of mental diseases in connection with the

State Hospitals for the Insane, begs leave to report as follows:

1. It is to the interests of the State that original research work should be carried on in relation to insanity, in order that the science should be advanced, and better methods of prevention, treatment and cure, discovered. This is of direct interest to the taxpayer, upon whom falls the burden of the care of the insane.

2. There should be one central laboratory in the State, wherein the energies of the best scientific men in the various departments of medicine related to insanity should be devoted wholly and exclusively to the prosecution of original research.

3. Such a laboratory, combining the labors of well-qualified workers in general pathology, neuro-pathology, psychology, chemistry, anthropology, and any other requisite branches, should be able to produce from year to year results which would be creditable to the State as a patron of science, as well as invaluable in advancing the knowledge of the methods of treatment and cure of mental disorders.

4. Each hospital for the insane should have upon its staff of medical officers one physician whose sole duty it should be to conduct ordinary autopsies and to carry on the routine duties of a clinico-pathological microscopist.

5. The central laboratory, or Pathological Institute, should be freely open to any qualified scientific men, for the prosecution of original research work, under the direction of the laboratory experts, preference always being given to the qualified men in the State Hospitals. But systematic teaching of fundamental principles should not be required from any of the departments of the Laboratory. The scientific men in charge of the various departments of the Pathological Institute should devote all their energies to original investigation and not be taxed, hampered or interfered with by medical men who are able to obtain instruction in fundamental principles elsewhere, without cost to the State.

6. The central laboratory for original research should be a part of a reception hospital for the insane, situated on Manhattan Island.

Frederick Peterson, President; Joseph Collins,
B. Sachs, Samuel B. Lyon,
Charles L. Dana, Lewis A. Conner,
Graeme M. Hammond, William D. Granger,
Ralph L. Parsons, Edward D. Fisher,
J. Arthur Booth, M. Allen Starr,
Pearce Bailey, Secretary.